

**Ministry of Long-Term Care**

Long-Term Care Operations Division  
Long-Term Care Inspections Branch

**Central West District**

609 Kumpf Drive, Suite 105  
Waterloo, ON, N2V 1K8  
Telephone: (888) 432-7901

## Original Public Report

<b>Report Issue Date:</b> July 9, 2024
<b>Inspection Number:</b> 2024-1242-0003
<b>Inspection Type:</b> Complaint Critical Incident
<b>Licensee:</b> Caessant-Care Nursing and Retirement Homes Limited
<b>Long Term Care Home and City:</b> Caessant Care Arthur Nursing Home, Arthur

## INSPECTION SUMMARY

The inspection occurred onsite on the following date(s): May 31, June 7, 11-14, 19, 20, 2024

The inspection occurred offsite on the following date(s): June 19, 2024

The following intakes were inspected:

- Intake #00110222 regarding the home's Falls Prevention and Management Program
- Intake #00112719 regarding a change in a resident's condition
- Intake #00114335 regarding concerns about a resident's altered skin integrity of unknown cause.

The following **Inspection Protocols** were used during this inspection:

Resident Care and Support Services  
Infection Prevention and Control  
Prevention of Abuse and Neglect  
Falls Prevention and Management

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## INSPECTION RESULTS

### WRITTEN NOTIFICATION: Reporting and Complaints

NC #002 Written Notification pursuant to FLTCA, 2021, s. 154 (1) 1.

**Non-compliance with: FLTCA, 2021, s. 28 (1) 1.**

Reporting certain matters to Director

s. 28 (1) A person who has reasonable grounds to suspect that any of the following has occurred or may occur shall immediately report the suspicion and the information upon which it is based to the Director:

1. Improper or incompetent treatment or care of a resident that resulted in harm or a risk of harm to the resident.

The licensee has failed to ensure that the care provided to a resident which resulted in several altered skin integrity was reported when improper care was suspected.

**Rationale and Summary:**

A resident was identified with multiple altered skin integrity of unknown cause.

The Director of Care (DOC) said they suspected that the resident sustained the altered skin integrity when they displayed responsive behaviours during care. They said care should have never been provided to the resident when the resident was displaying responsive behaviours. They said that staff had used poor judgment when they provided care to the resident.

Failure to report an incident where improper care was suspected may prevent the Director from being able to respond in a timely manner.

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**Sources:** A resident's progress notes, skin assessments, the home's investigation notes, and an interview with the DOC. [606]